# Mississippi's Failure

## Maternal and Reproductive Healthcare

ACLU
Mississippi

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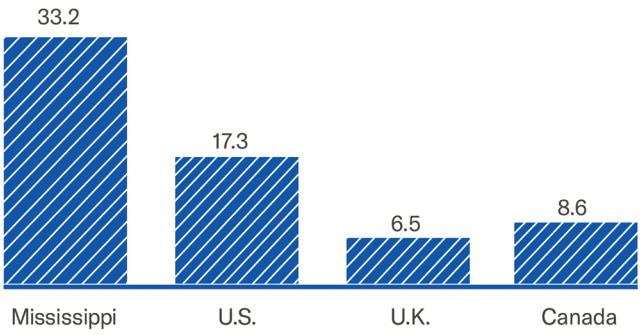
## Mississippi is an inherently dangerous place to give birth.

Mississippi has one of the highest maternal mortality rates not only in the United States[1] but also in developed nations.[2] Between 2013 and 2016, the average maternal mortality rate in Mississippi was 33.2 deaths per 100,000 live births.[3] This is almost twice as high as the national average (17.3 deaths per 100,000 live births). By comparison, the UK's rate is 6.5 deaths per 100,000 and Canada's is 8.6.[4]

Black women in Mississippi fare worse than their white counterparts. The maternal mortality rate for Black women is nearly three times as high as that of white women (51.9 deaths per 100,000 live births compared to 18)[5] and Black women frequently lack the financial means to access reproductive healthcare. While Mississippi has the highest poverty rate for women in the nation overall (20 percent compared to the 12 percent national average),[6] the poverty rate

**Maternal Mortality** (per 100,000)



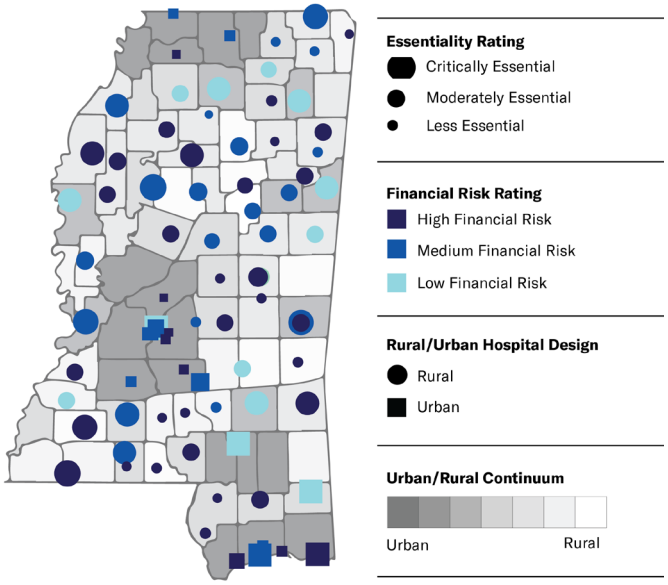

for Black women in the state is almost three times that of white women. White women in Mississippi face a pay disparity of 75 cents for every dollar white men make, whereas Black women experience an even bigger pay gap of 56 cents to the dollar.[7]

In addition to the medical risk and financial strain reproductive healthcare can cause for pregnant people in Mississippi, it also presents geographic barriers to residents in rural parts of the state. As of 2021, over half of the state's nearly three million residents live in a rural area.[8] According to a 2019 report, "Mississippi has more rural hospitals at risk of closing than any other state in this country," with 31 of the 64 hospitals that service this population at high risk of closing.[9] This means that "the most medically underserved state" is poised to lose even more physicians and further place Mississippians at medical risk simply because they are not close enough to a provider.[10]

Last year, Harmony Stribling, a pregnant mother from Belzoni, and her unborn child died from pre-eclampsia while en-route to the closest hospital from their home – a nearly thirty minute drive away.[11] Although doctors later acknowledged Stribling likely would have passed away regardless, her baby, Harper, could have been saved with "immediate access to supplemental oxygen."[12]

Mississippian's access to reproductive healthcare has been further curtailed since the Dobbs decision. With the closure of Jackson Women's Health Organization, Mississippians no longer have access to a facility and physicians that specialize in terminating pregnancies. The University of Mississippi Medical Center does have a maternal medicine fellowship for doctors, but no family planning fellowship, which has traditionally focused on termination, exists in the state. In July 2022, "the only neonatal intensive care unit in the . . . Delta . . . closed, moving lifesaving care for ill or premature newborn babies about two hours away by car."[13] Greenwood Leflore Hospital is also closing its labor and delivery unit, meaning local women "will need to travel about 45 minutes to give birth at a hospital."[14]

**Financial Risk & Essentiality in Mississippi Hospitals**



## Mississippi state government does not care about pregnant people and has done nothing to improve access to reproductive healthcare.

About 700 women in the United States die each year of pregnancy-related complications.[15] A 2019 CDC study of 2011-2015 data found that 3 in 5 of these deaths were preventable.[16] A more recent CDC study of 2017-2019 data found the rate to be even higher, with over 80% of deaths in the first year after pregnancy deemed preventable.[17] Despite these alarming statistics, legislators in Mississippi are failing to do the bare minimum to enact policies and laws which will prevent these deaths.

During the 2022 legislative session, there was popular, bipartisan support to extend postpartum Medicaid coverage past its current two months. The bill "overwhelmingly" passed in the Senate, but House Speaker Philip Gunn failed to bring it to the House floor for a vote,[18] showing a callous disregard for the 60% of births in the state that are covered by Medicaid.[19] Gunn made it clear that he viewed such a bill as expanding Medicaid in general, saying that "I believe we should be working to get people off Medicaid as opposed to adding more people to it."[20] However, as reporter Isabelle Taft pointed out in *Mississippi Today*, postpartum Medicaid expansion would *not* add people to Medicaid – it would simply extend the length of coverage for those who already qualify.[21]

Limited abortion exceptions and the closure of Jackson Women's Health Organization will force many Mississippi women to carry an unwanted pregnancy to term. Current estimates place the number of additional births at 5,000 – a number for which state officials admit they are vastly unprepared.[I, 22] Mississippians wishing to terminate a pregnancy that does not fall within the narrow exceptions will have to travel out of state. The closest abortion provider to Jackson is in Columbus, Georgia – an almost six hour drive away - [23] which, for many pregnant people, will not be an option. Georgia's current state laws prohibit abortions after six weeks, a time period in which few women know they are pregnant, and require a 24 hour waiting period between appointments to receive an abortion.

If Mississippi women do not fall under Georgia's six-week mark, they may instead choose to drive at least seven hours to Illinois or Florida. Abortions in Illinois are available until viability, while Florida abortions, like Georgia, require a 24 hour waiting period and only go up to 15 weeks and six days in a pregnancy. The state of Florida is currently in court against abortion clinics over whether the 15 week ban can be upheld based on a potential violation of the state's constitution.[24]

Besides the geographical constraints of accessing an abortion, many Mississippi women may not be able to afford an abortion. According to the Guttmacher Institute, in 2014, over half of all abortion patients (53%) paid for the procedure out of pocket.[25] Women are often forced to pay out of pocket despite qualifying for Medicaid because the Hyde Amendment limits using federal funds only for abortions of pregnancies arising from rape or incest, or when the pregnancy poses a risk to the patient's life. States may extend funding past the federal limitations, but Mississippi, Florida, and Georgia do not.[II26]

Without insurance coverage, a pregnant person seeking an abortion can expect to spend about $500 to almost $1200 for the procedure, depending on the age of the pregnancy at the time of termination.[27] The average abortion patient is already a mother and has a low income, meaning she must stretch her limited means to not only cover the abortion but also provide for childcare during her trip to the clinic, particularly in states with a 24 hour waiting period.[28] For women "whose income is at the higher end of Medicaid eligibility in the states [like Mississippi, Georgia, and Florida] that adhere to the Hyde Amendment requirements, paying for an abortion at 10 weeks of pregnancy would take nearly a third of her monthly family income."[29] An abortion later in pregnancy, at 20 weeks, "would take almost 90% of her monthly income."[30] A significant number of American adults (over 40%) in a 2016 survey acknowledged that they would be unable to cover a $400 emergency expense or that they would have to borrow or sell something to obtain the funds.[31] This number doesn't include the added costs of travel, childcare, and lost wages from taking time off work if an employer does not provide sick leave for the procedure.

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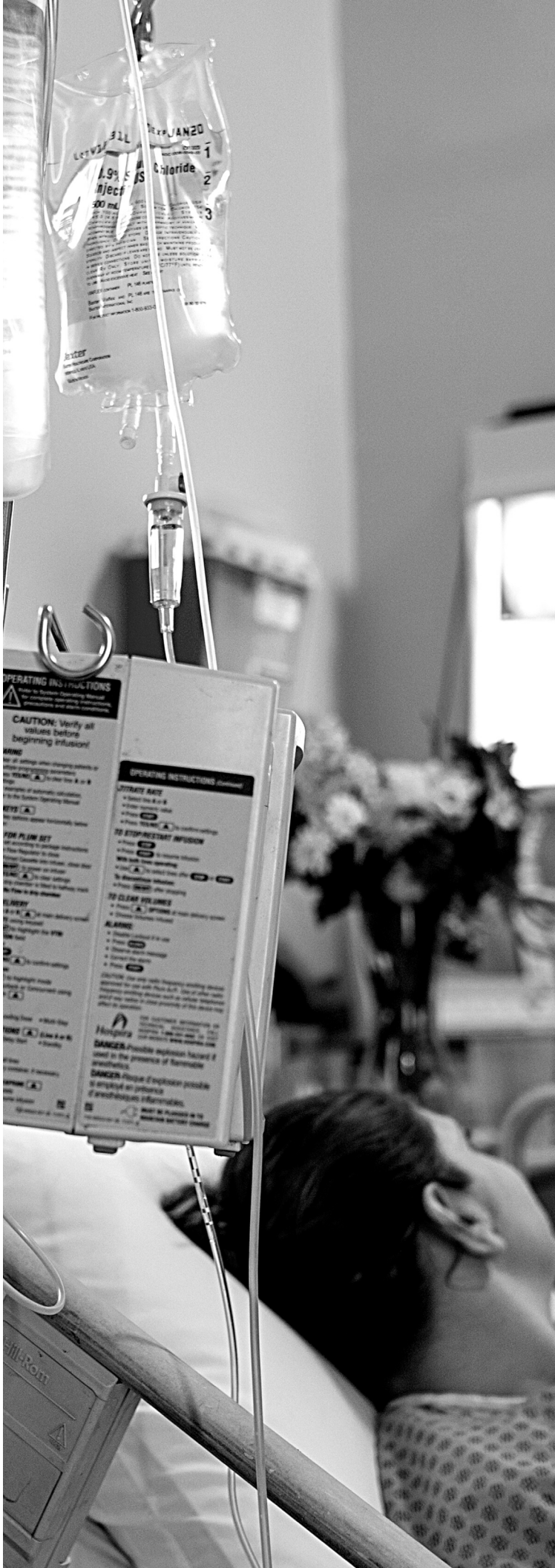
[I]Governor Tate Reeves frequently refers to himself as a "numbers guy," but he does not seem to have done the math on the cost of unwanted pregnancies. According to the Guttmacher Institute, "a publicly funded birth in 2010 cost an average of $12,770 in prenatal care, labor and delivery, postpartum care and 12 months of infant care." Adjusted for inflation, that cost rises to over $17,000. By comparison, an abortion out-of-pocket often costs $500-1200. https://www.guttmacher.org/report/public-costs-unintended-pregnancies-and-role-public-insurance-programs-paying-pregnancy

Mississippi government has also limited the ability of people to obtain healthcare to prevent pregnancy, and ultimately, a pregnancy-related death. During the COVID-19 pandemic, the state used a "rare U.S. Health and Human Services public health emergency provision" to divert Title X funding away from family planning services. By reassigning public health staff to the state's lackluster COVID-19 response, family planning "care was reduced by at least half."[III, 32]

The state has also historically promoted and encouraged abstinence-only education, failing to inform its citizens of various ways to avoid pregnancy and engage in healthy sexuality. 2011 legislation mandated that schools teach either "abstinence-only" or "abstinence-plus" education, with a majority of schools choosing "abstinence-only."[33] The state has no standard regarding medically accurate sex education instruction, and any curriculum must inform students of current state law related to homosexual activity. Abstinence-only education promotes the idea that sex should only occur in a marriage and does not make any mention of abortion. Instructors are not permitted to demonstrate effective use of a condom or contraceptives. In abstinence-plus curriculum, abstinence is still primarily encouraged but "information on contraception, and resources available for safer sex practices" is encouraged.[34] It's clear that the preferred focus on abstinence-only programs without information about how to proactively prevent pregnancy is not working: Mississippi has the highest teenage pregnancy rate in the nation as of 2020.[35]

*The same Mississippi OB-GYN reported seeing three pregnancies where the fetus had anencephaly, a fatal failure to develop part of the brain and skull, within a matter of weeks. This physician was unable to terminate these non-viable pregnancies under Mississippi's laws and had to tell their patients to go out of state or carry them to term.*




[II]Illinois does extend coverage for almost all abortions, making it the most realistic option for women from Mississippi traveling out of state for abortion care. https://www.kff.org/medicaid/state-indicator/abortion-under-medicaid/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D

[III]It is unclear just how much money was shifted away from reproductive healthcare. Reporter Erica Hensley, who broke the story on the state's diversion of staff, says she was stonewalled with FOIA requests to MSDH. Overall, the department moved about half of its staff to cover vaccination pop-up sites, which left many clinics with little or no employees to provide reproductive healthcare. In 2019, the health department "served 35,120 patients – about a third of the women of reproductive age without insurance in the state. New federal reporting shows the state served about 4,000 fewer patients in 2020."

## The current abortion restrictions prevent access to adequate healthcare for miscarriages and non-viable pregnancies.

In addition to forcing women to carry unwanted pregnancies to term, Mississippi also forces women to go through the physical and mental trauma of carrying a wanted but ultimately non-viable pregnancy to term. Many legislators assume that a non-viable pregnancy is not "life-threatening." As one Mississippi OB-GYN[IV] noted, simply being pregnant heightens a woman's risk for fatality – so forcing women to carry to term a non-viable pregnancy places them at risk of being a maternal mortality statistic. Under the Mississippi Code, abortions cannot be performed based on "genetic abnormality."[36] In practice, this means that physicians are not permitted to humanely terminate a pregnancy in which the fetus has no possibility of surviving past birth. Women with this condition must go through months of pregnancy knowing they will not produce a living child or scrape together the time and resources to seek healthcare out of state. The same Mississippi OB-GYN reported seeing three pregnancies where the fetus had anencephaly, a fatal failure to develop part of the brain and skull, within a matter of weeks. This physician was unable to terminate these non-viable pregnancies under Mississippi's laws and had to tell their patients to go out of state or carry them to term.

Fear of prosecution and the state's restrictive abortion laws will prevent Mississippi physicians and pharmacists from safely prescribing numerous medications, including mifepristone and misoprostol, which, in addition to inducing an abortion, are also used to treat miscarriages. A rural Ob-Gyn reported that it is difficult to get mifepristone and misoprostol in her community. These medications are used by the physician for patients whose fetus has died in-utero. Due to her uncertainty about whether a pharmacist will fill such a prescription, the physician has instead been performing dilation and curettages on these patients. At present, she sees about one fetal demise per week. Instead of having to undergo a medical procedure, these patients could safely take mifepristone and misoprostol at home.

Additionally, patients may lose or struggle to obtain prescriptions for abortifacient drugs that are used for other purposes. A Jackson pharmacist noted that misoprostol, which is often used in combination with methotrexate for an abortion, can also be used for patients with a history of stomach bleeds. Patients who took hydroxychlorine during the pandemic were switched to methotrexate after widespread misinformation about hydroxychlorine for Covid treatment. Now, they may be unable to get methotrexate.

## The abortion exception for "life-threatening" conditions is not adequate to save a pregnant woman's life.

Although Mississippi has an exception for abortions performed when a pregnancy threatens a mother's life, the statute itself is vague and doctors so far have received no guidance from state officials on when and if they may make these judgment calls without risk of prosecution. The state's largest trauma center, the University of Mississippi Medical Center, has yet to release any information on how it will determine which pregnancies qualify as life-threatening and how it will protect physicians from criminal charges. While a physician should feel free to make calls based on his or her own professional judgment, the lack of guidance means patients will receive disparate care based on a doctor's willingness to take on risk, as well as their own personal beliefs about abortion. A practitioner or nurse who identifies as "pro-life" may refuse to perform or assist in an abortion. If they work at a state hospital like UMMC and the woman dies, the woman's family may be left with limited legal recourse, as state hospitals are frequently shielded from tort liability with few exceptions.

Ironically, abortion is much safer than giving birth. In 2018, the CDC identified only two deaths related to abortion, and that between 2013-2018, the rate of death for legal induced abortions was .41 deaths per 100,000 abortions.[37] By comparison, the National Institute for Health reported 658 maternal deaths and 277 late maternal deaths in 2018, for a rate of 17.4 deaths per 100,000 live births.[38] Technically, this means that in 2018, giving birth was over 42 times more dangerous than having an abortion. Considering that Mississippi Black women have an even higher death rate due to pregnancy than the national average, this means that abortion for a non-viable pregnancy is a far safer option for that community than being forced to carry the fetus to term.

[IV]The ACLU had conversations during the fall of 2022 with a Jackson ob-gyn, a rural ob-gyn and a Jackson pharmacist familiar with women's and maternal healthcare in order to gain better understanding of how the current abortion restrictions and potential further legislative restrictions will impact healthcare in the state. These conversations are referenced throughout the report.

## The abortion exception for rapes is not adequate because it requires a report to law enforcement and many victims are unlikely to make a timely report, if any.

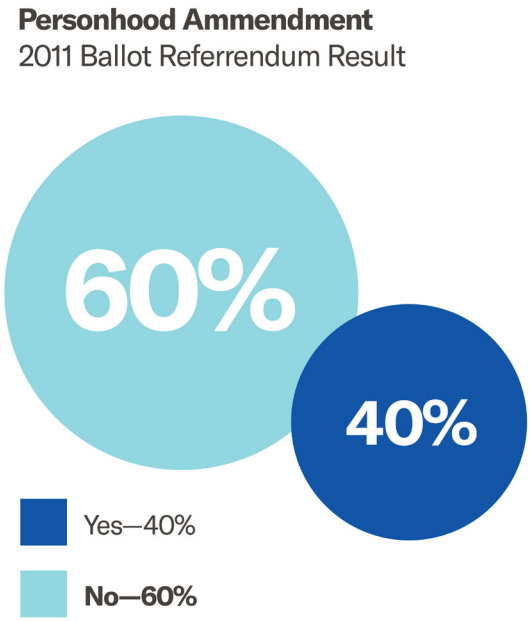
It is indisputable that sexual assault is one of the most traumatic events a person can experience. Forcing a woman to carry a pregnancy conceived in rape is abominably inhumane, without any regard for her mental health or physical well-being. Currently, Mississippi's rape exception requires that a victim must report her rape to law enforcement, a process that often re-traumatizes a victim in the process.[39] According to RAINN, only 310 out of every 1,000 sexual assaults in the United States are reported to the police.[40] In other words, more than 2 out of 3 go unreported. Many victims have entangled or close relationships with their offender, which means they do not report the crime in order to prevent further abuse. In a survey of sexual assault victims who did not report from 2005-2010, a fifth (20%) did not report because they feared retaliation. Others believed the police could not or would not do anything to help and some did not want to get their assailant in trouble.[41]

## Any personhood laws will threaten access to both fertility treatments and contraception.

Mississippi Governor Tate Reeves and Attorney General Lynn Fitch have repeatedly gone on the record to say they are "promoting a culture of life"[42] and that Mississippi will "empower women."[43] However, it is clear their rhetoric means prioritizing the lives of some women and children, not all. When women facing difficulty conceiving undergo IVF treatments, multiple embryos are created. Given the expensive cost of IVF at baseline, not everyone can afford to perpetually store embryos – meaning several can be destroyed in the process. Personhood laws seek to recognize that life begins at fertilization, thus directly contradicting the scientifically accepted definition that a pregnancy begins when a fertilized egg is implanted, not when it is fertilized.[44] If a personhood law goes into effect, people who are trying to start a family could be criminalized for destroying embryos or IVF itself could be banned.

Additionally, personhood laws threaten the ability of women to avoid pregnancy altogether. Several "pro-life" groups, such as Pro-Choice Mississippi, the non-profit that sued to continue protesting outside the now-closed Pink House, view birth control and IUDs as abortifacients, even though this is factually incorrect. They believe that disrupting implantation causes an abortion, which is also incorrect.[45] Fertilized eggs may fail to implant for several reasons, not only because their implantation has been disrupted by hormonal birth control. Plan B pills, which also prevent implantation of a fertilized egg, may also be under attack. Alliance Defending Freedom, the group that authored Mississippi's 15 week abortion ban,[46] views Plan B as an abortifacient.[47] While Governor Reeves has said that he doesn't think bills banning contraception will come up in the legislature, he also says he believes life begins at conception, which, for many in the pro-life camp, means at fertilization. [48]

The campaign for a personhood amendment has already been tried – and overwhelmingly failed – in Mississippi. State residents understand that reproductive freedom is at risk when policymakers attempt to regulate the idea of when a pregnancy begins from an unscientific perspective. In 2011, nearly 60% of Mississippi voters voted against an amendment that would have legally defined life as beginning at fertilization.[49] Speaker Gunn supported the amendment, despite its vast disapproval by Mississippians. As noted by reporter Ashton Pittman in the Mississippi Free Press, the original website supporting the ballot initiative said the campaign opposed "birth control methods which act as abortifacients," including "forms of the pill which act to prevent implantation of the newly formed human into the lining of the womb [and] forms of the IUD."[50]



## Even after a "successful" birth, women face mental, physical and monetary hardships which the state of Mississippi has failed to provide for by refusing to expand Medicaid.

Between 2016 and 2020, over 60% of all births in Mississippi were covered by Medicaid.[51] This percentage is vastly higher than the national average: in 2018, Medicaid paid for 43 percent of all births.[52] As of April 2022, 40,000 Mississippians were covered under pregnancy Medicaid.[53]

A large portion of Mississippi women and children live in poverty without adequate access to healthcare and reproductive services. As of 2016, 21.9% of Mississippi women aged 18 and older were in poverty, with nearly a third of Black women residents in poverty.[54] While insurance coverage has improved since 2010, when over a quarter of all Mississippi women between 15 and 44 were uninsured, about one in six women of childbearing age were still uninsured a decade later.[55] Because of lower incomes and a lack of financial opportunities, Medicaid remains a critical player for ensuring women in our state receive healthcare during pregnancy and beyond.

While one might presume the majority of maternal deaths occurred during pregnancy (21.6%) or on the day of delivery (13.2%), a recent CDC study of maternal deaths between 2017 and 2019 found that nearly a third occurred 43-365 days postpartum.[56] Given that Mississippi Medicaid only provides coverage up to 60 days postpartum, it is clear we are missing out on a crucial time gap in which we could prevent more deaths. Even with the current coverage, the state has ineffectively provided it or informed women they can use it: during the pandemic many women received erroneous letters that they had been kicked off Medicaid.[57]

Furthermore, it is unclear whether current postpartum coverage includes treatment for postpartum depression. At the least, two months of treatment is not enough to treat a mental health problem that can last for much longer. Postpartum depression is not an uncommon diagnosis: around one in seven women may develop it.[58] If a mother is covered by Medicaid for at least a year after giving birth, she will receive coverage for up to 36 individual psychotherapy sessions, 24 family psychotherapy sessions, and 40 group therapy sessions.[59] Medicaid also covers acute partial hospitalization, intensive outpatient, inpatient psychiatric and psychosocial rehabilitation services.[60] A Mississippi OB-GYN relayed a tragic story where a mother who had recently given birth committed suicide by off-roading her car; she had failed to receive treatment for postpartum depression, which would have been covered by Medicaid expansion.

### Which pregnant women qualify for Medicaid?

Pregnant women in Mississippi making no more than a certain monthly income (determined by 194% of the federal poverty line and family size) qualify to receive benefits throughout their pregnancy and two months postpartum. They also receive family planning benefits for one year. Any child born to a Medicaid eligible mother also receives benefits for one year.[61]

**Pregnant Women (any age) and Family Planning Waiver (13-44 years old) | 194% FPL[62]**

| Family Size | Monthly Income |
|---|---|
| 1 | $2,255 |
| 2 | $3,037 |
| 3 | $3,820 |
| 4 | $4,603 |
| 5 | $5,385 |
| 6 | $6,168 |
| 7 | $6,951 |
| 8 | $7,733 |

*For more than eight members add $764 for each additional person*

Non-citizens and undocumented immigrants qualify for coverage of labor and delivery services, and their children also qualify for benefits for one year after birth, but it is unclear if these mothers may receive covered postpartum services.[63]

### How can women apply for Medicaid?

Pregnant women can apply online, in person, or via the mail. They can also call the statewide or a regional office to have an application mailed to them.[64]

Some qualified hospitals can "immediately enroll patients [like pregnant women] in Medicaid who are determined eligible for Medicaid by authorized hospital staff. HPE provides temporary Medicaid eligibility but also allows access to continuing Medicaid coverage provided the HPE decision includes filing a full Medicaid application." The hospital "assist[s] the HPE applicant in completing and submitting the full application for Medicaid before the end of the HPE period."[65]

### What does postpartum Medicaid currently cover?

According to the Mississippi Division of Medicaid's Eligibility Policy and Procedures Manual, a recently pregnant woman can apply for Medicaid to retroactively cover her labor and delivery.[66] She will then receive benefits postpartum for up to two months while her child will be covered for a year. If she is between the ages of 13 and 44, she will also receive family planning coverage for a year. Family planning services include "counseling services, medical services and pharmaceutical supplies and devices to aid those who decide to prevent or delay pregnancy."[67] It does not cover IVF, fertility treatments, hysterectomies, or abortions.

Additionally, postpartum coverage includes a medical risk screening for morbidity or mortality from "unstable medical and/or mental health conditions."[68] If a woman is found to be at risk, Medicaid will cover additional services, including nutritional counseling and assessment, a mental health assessment, a home visit for postnatal assessment, and behavioral health prevention education services. The Mississippi State Plan for Medicaid does not clarify whether these "behavioral health prevention education services" include therapy for postpartum depression.

Failure to expand postpartum Medicaid means that women often do not receive adequate birth control to prevent future pregnancies. As one rural OB-GYN reported, "it is very rare to get a patient postpartum conception within the first 60 days." The process to get a Medicaid patient an IUD or Nexplanon is complicated – paperwork must be sent off by the doctor, then that doctor has to accept a call from the pharmacy authorized to fill it. The same OB-Gyn recalled that she had ordered an IUD for a young woman who just had her third baby at the beginning of August and as of October, the IUD still hadn't arrived.

*Failure to expand postpartum Medicaid means that women often do not receive adequate birth control to prevent future pregnancies.*


## Mississippians overwhelmingly do not agree with the Dobbs decision and the overturning of Roe v. Wade.

The majority of Mississippians oppose the Supreme Court's extreme decision in Dobbs to overturn Roe v. Wade and deny women bodily autonomy. July 2022 polling done by the ACLU of Mississippi in conjunction with Chism Strategies revealed that over half of Mississippians oppose the Court's decision in Dobbs. 81% of Mississippians believe that abortion should be legal with some restrictions while nearly a third believe that abortion should be legal in all cases. Unlike the radical restrictions proposed by conservative lawmakers like Speaker Gunn, who expressed that a 12 year old incest victim should be forced to carry a pregnancy to term,[69] a mere 18% of Mississippians believe that abortion should be illegal in all cases.

Overall, Mississippians believe in bodily autonomy and oppose prosecutions or investigations of women for having an abortion. 84% agree that individuals have a general right to privacy in making decisions related to their persons. 83% oppose prosecutions of women having abortions. During the 2022 legislative session, Speaker Gunn proposed a bill that would allow the state to collect medical records, including menstrual cycle dates and internet browsing history of anyone suspected of having an abortion. Nearly 80% of state residents oppose such legislation. 86% of Mississippians also overwhelmingly oppose legislation that would permit state government officials to learn if they have visited an online pharmacy to obtain abortion pills. Additionally, despite Mississippi's current prohibition on telehealth services for mifepristone (an abortion pill), nearly half of Mississippians support allowing physicians to prescribe it via telehealth.

Mississippians (over 70%) also correctly understand that emergency contraception such as IUDS and Plan B are not methods of abortion. Over half oppose personhood laws that would define a fertilized egg as a person, similar to the number of Mississippians who rejected the 2011 personhood amendment.


**80% of voters oppose** state collection of medical records, including internet history and menstrual app data, of anyone suspected of having an abortion.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Finally, an overwhelming majority of Mississippians agree that the current state legislature is failing to invest in the well-being of women and children. While Governor Reeves has repeatedly stated that he wants to create a pro-life culture in Mississippi where all women and babies are supported, document requests filed by the ACLU and Mississippi Today show that he lied about conducting an "extensive review" of legislation needed to create a supportive environment for pregnant women.[70] Over three-fourths of Mississippians support the expansion of Medicaid despite the fact that Reeves has repeatedly gone on the record to oppose it,[71] and nearly 90% of Mississippians support the legislature funding health department offices in each county.

# Endnotes

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